ARC 3296C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4 and 2017 Iowa Acts, House File 653, section 12(15)(a)(2), the Department of Human Services hereby amends Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 80, "Procedure and Method of Payment," Iowa Administrative Code.

These amendments implement the cost-containment strategy to ensure that total reimbursement for Medicare Part A and Part B crossover claims is limited to the Medicaid reimbursement rate.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 3163C** on July 5, 2017. These amendments were also Adopted and Filed Emergency and published as **ARC 3159C** on the same date and became effective July 1, 2017.

The Department received comments from seven respondents during the public comment period. The comments from the respondents and responses to the comments from the Department are as follows:

Comment 1: Six respondents asked that the Department exempt behavioral health services from this policy change. Two of the respondents also specifically requested to exempt community mental health centers (CMHCs).

Department response 1: The Department was unable to make changes to these amendments based on the comments of the respondents. These amendments are required by 2017 Iowa Acts, House File (HF) 653, enacted during the 87th Session of the Iowa General Assembly. The enacted legislation does not exempt behavioral health services or CMHCs.

Comment 2: One respondent did not believe the proposed effective date aligns with the language approved by the Legislature in HF 653.

Department response 2: The Department was unable to make changes to these amendments based on the comment of the respondent. The effective date of the Adopted and Filed Emergency amendments is July 1, 2017, and must be approved by the Centers for Medicare and Medicaid Services (CMS).

Comment 3: A respondent noted that the Department's informational letter states that "Iowa Medicaid will calculate the Medicaid fee at 50 percent of the Medicare allowed amount for the [noncovered] service." The respondent is seeking additional information about the 50 percent rate selection made by the Department.

Department response 3: The Department was unable to make changes to these amendments based on the comment of the respondent. The 50 percent rate is similar to how other state Medicaid agencies calculate a Medicaid allowed amount for noncovered Medicaid services.

Comment 4: One respondent requested clarification as to whether affected providers are allowed to bill the client the amount that will no longer be paid by Medicaid.

Department response 4: The Department was unable to make changes to these amendments based on the comment of the respondent. Section 4714 of the Balanced Budget Act of 1997 bars Medicare providers from billing a qualified Medicare beneficiary (QMB) under any circumstances. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB.

Comment 5: A respondent commented that federal authority allows state Medicaid programs the option to use "lesser of" payment policies to pay for the patient liabilities for dual eligible, as it is proposed in this amended rule and that states, however, can choose the service types to which they apply these policies and are not obligated to apply them across the board and that other states have chosen this option.

Department response 5: The Department was unable to make changes to these amendments based on the comment of the respondent. The 50 percent rate applies across the board, similar to other states.

Technical change to the amendments: In the process of reviewing these amendments, the Department determined that a technical change to these amendments was necessary to ensure that the Department differentiates the processes for "fee-for-service" members and "managed care" members.

Accordingly, paragraph 80.2(2)"h" in Item 2 has been rescinded and a new paragraph adopted in its place, and a new paragraph 80.2(2)"i" in Item 3 has been added.

New paragraph 80.2(2)"h" reads as follows:

"h. For fee-for-service members, providers billing claims for Medicare beneficiaries that do not cross over electronically to the Iowa Medicaid enterprise must submit the following electronically, in accordance with the All Providers, IV. Billing Iowa Medicaid manual, located at http://dhs.iowa.gov/sites/default/files/All-IV.pdf:

"(1) Form UB-04.

"(2) Form CMS-1500. The Explanation of Medicare Benefits (EOMB) is only required when requested by the Iowa Medicaid enterprise."

New paragraph 80.2(2)"i" reads as follows:

"i. For managed care members, providers billing claims for Medicare beneficiaries that do not cross over electronically must submit the following electronically:

"(1) Form UB-04 and the Explanation of Medicare Benefits (EOMB); and

"(2) Form CMS-1500 and the Explanation of Medicare Benefits (EOMB)."

The Council on Human Services adopted these amendments on August 9, 2017.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be requested under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4 and 2017 Iowa Acts, House File 653, section 12(15)(a)(2).

These amendments will become effective October 4, 2017, at which time the Adopted and Filed Emergency amendments are hereby rescinded.

The following amendments are adopted.

ITEM 1. Amend subrule 79.1(22) as follows:

79.1(22) *Medicare crossover claims ~~for inpatient and outpatient hospital services~~.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for Medicare crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

"~~Crossover~~ Medicare crossover claim" means a claim for Medicaid payment for ~~Medicare-covered inpatient or outpatient hospital~~ services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. ~~Crossover~~ Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid ~~prospective~~ reimbursement for the ~~services~~ service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

~~*"Medicaid reimbursement"* means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.~~

"Medicare-allowed amount" means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Medicare deductible and coinsurance amounts" means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

~~*"Medicare payment amount"* means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.~~

"Medicare provider reimbursement" means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Third-party payment" means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. ~~Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.~~ Covered Medicare crossover claims shall be paid by Medicaid at the lesser of:

~~(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.~~

~~(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:~~

~~1. The Medicaid-allowed amount minus the Medicare payment amount; or~~

~~2. The Medicare coinsurance and deductible amounts applicable to the claim.~~

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

ITEM 2. Rescind paragraph **80.2(2)"h"** and adopt the following **new** paragraph in lieu thereof:

h. For fee-for-service members, providers billing claims for Medicare beneficiaries that do not cross over electronically to the Iowa Medicaid enterprise must submit the following electronically, in accordance with the All Providers, IV. Billing Iowa Medicaid manual, located at http://dhs.iowa.gov/sites/default/files/All-IV.pdf:

(1) Form UB-04.

(2) Form CMS-1500. The Explanation of Medicare Benefits (EOMB) is only required when requested by the Iowa Medicaid enterprise.

ITEM 3. Adopt the following **new** paragraph **80.2(2)"i"**:

i. For managed care members, providers billing claims for Medicare beneficiaries that do not cross over electronically must submit the following electronically:

(1) Form UB-04 and the Explanation of Medicare Benefits (EOMB); and

(2) Form CMS-1500 and the Explanation of Medicare Benefits (EOMB).

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 8/30/17.